TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM STRINDEN, MD

Respondent Name
BITCO GENERAL INSURANCE CORP

MFDR Tracking Number
M4-17-1948-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Corvel has denied payment for this code stating that 'this procedure is not compatible with another procedure on the same day.' I realize that, according to Medicare, the CCI edits do not allow payment of the add on code 69990 with 26356 or 35207, but Medicare DOES allow payment with the nerve repair code 64831. Because there are CCI edits with the other codes used (26356 and 35207), the 59 modifier was used to show that procedures which are not normally allowed together are appropriate in the present circumstances. 69990 (use of operating microscope) is an add-on code and it IS eligible for payment with only a select few codes. One of the primary codes must be used then it is eligible for payment. 64831 (nerve repair) is the primary code which will allow use of 69990. It doesn't matter that other codes for tendon repair and blood vessel repair were also used."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, William Dean Strinden, MD is not entitled to additional reimbursement for date of service 10/27/16; CPT Code 69990 based on DWC adopted outpatient hospital fee guideline, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided…CPT code 69990 (Secondary) may not be billed with CPT Code 26356 (Primary) based on Misuse of Column 2 code with Column 1. A modifier is not allowed to override this relationship."

Response Submitted By: CorVel/Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2016	CPT Code 26356-58	$0.00	$0.00
	CPT Code 26356-58-59	$0.00	$0.00
	CPT Code 35207-58-51	$0.00	$0.00
	CPT Code 64831-58-51	$0.00	$0.00
	CPT Code 69990-58-59	$600.00	$0.00

	CPT Code 12001-58-59	$0.00	$0.00
TOTAL		$600.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
    - 197-Payment adjusted for absence of precert/preauth.
    - R89-CCI: Misuse of Column 2 code with Column 1 code.
    - 16-Svc lacks info needed or has billing error(s).
    - W3-Appeal/Reconsideration.

Issues

Is the allowance of code 69990-58-59 included in the allowance of another code? Is the requestor entitled to reimbursement?

Findings

The disputed issue is whether the requestor is due reimbursement for code 69990-58-59 per 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

On the disputed date of service the requestor billed codes 26356-58, 26356-58-59, 35207-58-51, 64831-58-51, 69990-58-59 and 12001-58-59. The requestor appended modifiers "59-Distinct Procedural Service" and "58-Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period" to these codes.

According to the explanation of benefits, the respondent denied reimbursement for code 69990-58-59 based upon "R89-CCI: Misuse of Column 2 code with Column 1 code."

Per CCI edits, CPT codes 69990 is included in the allowance of codes 12001 and 26356 and a modifier is not allowed to differentiate the service.

The requestor appended modifier 59 to code 69990 which is further defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The requestor contends that payment is due because "69990 (use of operating microscope) is an add-on code and it IS eligible for payment with only a select few codes. One of the primary codes must be used then it is eligible for payment. 64831 (nerve repair) is the primary code which will allow use of 69990. It doesn't matter that other codes for tendon repair and blood vessel repair were also used." In support of the position, the requestor submitted a copy of Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 20.4.5, states "Effective January 1, 2000, the replacement code (CPT 69990) for modifier -20 - microsurgical techniques requiring the use of operating microscopes may be paid separately only when submitted with CPT codes: …64831."

The requestor also submitted a copy of CPT Corner, Use of Code 69990 has become confusing report which states, "Although CPT recommendations are often in flux until ultimate clarification are made, the current rules for the reporting of 69990 include: 69990 is not to be used with CPT codes where the use of the operating microscope is inherent in the code (e.g., free flaps)."

The Division reviewed the submitted documentation and finds the following:

- On the disputed date of service the requestor billed codes 26356-58, 26356-58-59, 35207-58-51, 64831-58-51, 69990-58-59 and 12001-58-59.
- Per CCI edits, CPT codes 69990 is included in the allowance of codes 12001 and 26356.
- The requestor appended modifier "59" to code 69990. Per CCI edits a modifier is not allowed to differentiate 69990 from 12001 and 26356.
- Modifier "59" requires the requestor to document a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The requestor did not support billing with modifier 59.
- The Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 20.4.5, did not provide an override to the CCI conflict of billing code 69990 with 12001 and 26356.

For the reasons stated above, the Division concludes that the respondent's denial of payment for code 69990-58-59 is supported. As a result, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		04/04/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.